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## Consider a Physician-Centered Practice

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Physicians are knowledge workers. According to one definition of knowledge workers, they have high degrees of expertise, education, or experience, and the primary purpose of their jobs is to create, distribute or apply their knowledge. Then it follows logically that building a job that meets their unique needs would require a physician-centered practice.

### Practice Development

Simply using the term "physician-centered practice" may be enough to make physicians question the strategy. After all, one of the goals of health systems today is to be patient-centered. But, in fact, it may be possible to have a physician-centered practice that actually delivers better care more effectively than one that is patient-centered.

As knowledge workers, physicians are at the top of the food chain in their practices. Other staff certainly have focused expertise and are necessary to the success and well being of the practice, but if clinical expertise and the use and delivery of clinical knowledge are the chief products of the practice, and the physician is the critical agent of that knowledge, then the physician is the center of the practice.

Unfortunately, clinical expertise, and the use and delivery of clinical knowledge are not always considered to be a practice's chief products. This is where conflict begins.

### A Clear Focus

In certain situations, numerous other people (utilization reviewers, for example) or tasks (such as paperwork) take center stage, diverting the physician's attention from delivering the chief product. Absent clear focus on the chief product, practices become derailed.

The physician-centered practice focuses everyone in the office on creating an environment in which physician knowledge can be delivered most effectively. Once this is accomplished, those situational issues are handled much more effectively.

There are five components to building the physician-centered practice.

1. Defining and measuring physician needs
2. Creating physician-centered staff responsibilities
3. Developing mutual expectations from and for patients
4. Effecting operational strategies and processes to support the physician, the staff, and the patient
5. Implementing financial procedures to pay for all the above.

Defining and measuring physician needs. This area is universally overlooked in terms of practice management, improvement, and other organizational and development approaches. Also, knowing and satisfying physician need is the basis for addressing all other practice needs and objectives in the physician-centered practice.

Any discussion of needs can range widely from the abstract and to the situational. But such discussion misses the point. Numerous studies have shown that each physician has highly definable needs that fall into various categories. Birkman International, a company in Houston that specializes in assessing behavioral work needs, has developed an instrument to categorize, measure, and define individual work needs.

Using such an instrument, physicians can identify and measure their specific work needs along functional categories. Then, we can use these categories to develop strategies, expectations, processes, policies, and procedures to manage staff communications and responsibilities, and practice work flow procedures and processes. Also, we can provide a framework for creating expectations of patients and to establish and manage patients' expectations.

Most physicians need to identify ways to set the practice's general tone, tenor, and orientation. They also need to analyze office situations and then develop appropriate strategies for each one. For example, they would need to create appropriate patient visit schedules, determine the appropriate billing reports and production information needed, and establish staff responsibilities. Using measurable data, physicians can set formal policies and procedures that help them remove much of the ambiguity from their practices.

Creating physician-centered staff responsibilities. If staff is helping the physician meet his or her needs, then through the physician's enhanced effectiveness the chief product of the practice will improve.

While you wouldn't describe your staff's primary role as making you happy, they must meet or help you meet your needs for you to be effective, and effectiveness breeds happiness. Therefore, physician needs-based criteria should be at the top of the list on your staff's job descriptions.

Developing mutual expectations from and for patients. If physicians or practices clearly define for patients their needs and expectations, most patients will try to comply. And, if patients are adequately helped to present their

needs and expectations to physicians and the practice, the physicians or practice can effectively address them. When developing expectations for patients, physician staff needs to understand that patient expectations must also meet the physician's needs.

Effecting operational strategies and processes to support the physician, the staff, and the patient. Now that the physician's needs are known, the physician should commit the resulting policies, processes, and procedures to paper. Using physician need data to create effective documentation further removes ambiguity from the practice and creates a platform for operational and strategic consistency and continuity.

Implementing financial procedures to pay for all the above. While in architecture, form follows function, in a physician practice, form follows finance. One of the greatest barriers to change is the belief that one can't afford to change. Therefore, a practice's finances must be in order and the financial aspects of a practice must be built to support the physician's needs in terms of total income and how that income is derived.

#### Key Differences

The physician-centered practice differs from any other practice management or development process in three important ways. First, it uses scientifically derived objective behavioral data as the foundation for shaping and building the practice. And, just as physicians use a combination of objective and subjective information for diagnosing patients, that same model is followed in diagnosing the physician's work and practice needs.

Second, the physician-centered practice approach is individually and internally focused. That is, physicians or practices aren't expected to comply with outside parameters as a measure of success.

Third, the physician-centered practice establishes a lifelong strategic and operational practice framework. Behaviorists have determined that each individual's work needs are static after the individual reaches maturity. Although the means to satisfy those needs may change, the end target is consistent. Therefore, unlike the latest practice management trend sweeping physician practices, the physician-centered practice can represent a consistent course for physicians to follow regardless of what style may be popular at any given time.

Physicians seeking to develop a more physician-centered practice can begin by defining their own work needs. Although the easiest way to do so is to engage a consultant who has the necessary tools and experience to guide this process, you can also perform some self-diagnosis. In determining your work needs, look to underlying pathologies of both happiness and frustration. Do scheduling mix-ups set you off, are you happiest having a casual lunch with your staff, do you always want more financial data than your billing staff provides? Then ask yourself if those reactions are indicative of needs met or unmet. Then ask how you can address them with new operational methods.

#### Avoiding Trends

When engaging in this process, you will likely be reminded that it's trendy today to be patient-centered. However, if understanding patients' needs and finding ways to better satisfy them, and helping patients understand how to communicate with you and you with them more effectively is the core of a patient-centered practice, then the physician-centered practice more than meets those requirements.

Most observers would agree that too many patient-centered efforts are cookbook-derived programs comprised of dos and don'ts. Knowledge workers prefer autonomy particularly regarding the detailed processes they follow when doing their work. Patient-centered programs generally remove that autonomy. But physician-centered practices use autonomy and build on it.

The objective of the physician-centered practice hinges on developing a practice more responsive to the physician. Happy physicians lead to happy staffs and happy and satisfied patients. Patients and staff come and go, but since by definition, the physician is in the practice for as long as it exists, it makes sense that the practice should fulfill his or her needs.

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